# Healthcare 101
## Terms and Definitions

**Do you sometimes get lost in all the unfamiliar terms associated with health plans? Here are some basic terms and definitions to help you get more familiar with the lingo!**

**HRA** — HRA stands for Health Reimbursement Arrangement/Account. With this type of plan, funds are put into an account by your employer for you to use to cover eligible health care expenses. There is a deductible but you can choose to be reimbursed with funds that you have in your Health Reimbursement Account. If you don't have enough money in your HRA to cover the full deductible, you are responsible for the remaining portion which is known as a "bridge" deductible.

**PPO** — PPO means Preferred Provider Organization. This is a plan design that requires members to pay an "up front" deductible and then a percentage of all remaining costs until the maximum out of pocket is reached. There is a network of providers and costs are lower when you see an in-network provider. You pay more (Up to 100% of the cost) if you decide to see a provider that is not in the network.

**EPO** — EPO stands for Exclusive Provider Organization. This is a plan design that requires a plan member to see in-network providers for care. If you see a provider outside the network, you pay 100% of the cost.

**Bridge** — Bridge is the portion of the deductible that you are responsible for in an HRA plan. If you have money in your HRA, the plan will apply that money first. Once your HRA is exhausted, you are responsible for "bridging" the difference between what the HRA covered and the full deductible.

**Premium** — Premium is the amount that you pay to be enrolled in the plan. It is just like the premium you pay for your car and home/renter's insurance. The amount of premium will vary depending on the plan you choose and whether or not you cover dependents.

**Co-Pay** — A type of insurance policy where the insured pays a specified amount of out-of-pocket expenses for healthcare services such as doctor visits and prescription drugs at the time the service is rendered, with the insurer paying the remaining cost.

**Co-insurance** — Co-insurance is the percentage of healthcare costs that you share with the plan once the deductible is met. For example, if the plan has an 80% co-insurance rate for a specific healthcare service, that means that once the deductible is met, the plan will pay 80% of the cost and you are responsible for the remaining 20%. Co-insurance levels may vary depending on the type of healthcare service you are receiving and whether or not you use an in-network provider.

**Deductible** — Deductible is the amount paid before the plan begins paying at a co-insurance rate. In a PPO plan, the deductible is paid by the member up front. In an HRA plan, the deductible is first paid via the Health Reimbursement Account, and the remaining portion (the "bridge") is paid by the member.

**Maximum out-of-pocket** — Maximum out of pocket is the amount that a member pays before the plan begins paying at 100%. Some things may not be included in the maximum out of pocket like premiums, deductibles, co-pays, expenses from out-of-network providers, services not covered by the health plan, etc.

**Preventive Care** — Preventive care includes services that help to prevent future illness. For a list of what's covered at $0 cost, go to http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html.

**In-Network** — In-network refers to a group of providers that have contracted with the plan to provide services to members at a reduced rate.

**Out-of-Network** — Out-of-network refers to all other providers that are not included in the plan's network.

**Third Party Administrator (TPA)** — Organization that administrates group insurance policies for an employer. This organization works with the employer as well as the insurer to communicate information between the two, as well as process claims and determining eligibility. HealthSCOPE is a Third Party Administrator.